

ACUTE STRESS DISORDER

BEHAVIORAL DEFINITIONS

1. Exposure to actual death of another or threatened death or serious injury to self or another, which resulted in an intense emotional response of fear, helplessness, or horror.
2. Experiences dissociative symptoms of numbing, detachment, derealization, depersonalization, amnesia, or reduction of awareness to surroundings.
3. Reexperience the event in thoughts, dreams, illusions, flashbacks, or recurrent images.
4. Marked avoidance of stimuli that arouse recollections of the trauma—whether through thoughts, feelings, conversations, activities, places, or people.
5. Symptoms of increased arousal such as difficulty sleeping, irritability, poor concentration, hypervigilance, exaggerated startle response, or motor restlessness.
6. Physical symptoms of chest pain, chest pressure, sweats, shortness of breath, headaches, muscle tension, intestinal upset, heart palpitations, or dry mouth.

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LONG-TERM GOALS

1. Stabilize physical, cognitive, behavioral, and emotional reactions to the trauma while increasing the ability to function on a daily basis.
2. Diminish intrusive images and the alteration in functioning or activity level that is due to stimuli associated with the trauma.
3. Assimilate the traumatic event into life experience without ongoing distress.
4. Confront, forgive, or accept the perpetrator of the traumatic event.

SHORT-TERM OBJECTIVES

1. Describe any bodily injury or physical symptom that has resulted from the trauma. (1, 2)
2. Describe the traumatic event, providing as much detail as comfort allows. (3, 4)
3. Describe the feelings that were experienced at the time of the trauma. (5)
4. Identify the impact that the traumatic event has had on daily functioning. (6, 7)
5. Avoid the geographic area surrounding the traumatic event. (8)
6. Identify distorted cognitive messages that promote fear

THERAPEUTIC INTERVENTIONS

1. Assist in getting the client to an urgent care or emergency department for medical consultation.
2. Make a referral to a physician for a medical evaluation.
3. Actively build a level of trust with the client in individual sessions through consistent eye contact, unconditional positive regard, and warm acceptance to help increase his/her ability to identify and express feelings.
4. Gently and sensitively explore the recollection of the facts of the traumatic incident.

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- and replace those messages with reality-based self-talk that nurtures confidence and calm. (9, 10)
7. Implement behavioral coping strategies that reduce tension. (11, 12)
8. Design an activity to be implemented on the anniversary day of the event or around major life events (i.e., holidays, graduation). (13, 14, 15)
9. Implement the stress inoculation activity and discuss the reaction after the trigger event has occurred. (15, 16)
10. Report the termination of flashback experiences. (17, 18)
11. Verbalize an increased understanding of the beliefs and images that produce fear, worry, or anxiety. (9, 19)
12. Cooperate with an evaluation for psychotropic medication. (20)
13. Take psychotropic medications as prescribed and report any side effects to appropriate professionals. (20, 21)
14. Decrease symptoms of autonomic arousal by learning and implementing relaxation techniques. (10, 22, 23, 24)
15. Increase daily social and vocational activities. (11, 25)
5. Explore the client's emotional reaction at the time of the trauma.
6. Ask the client to identify how the traumatic event has negatively impacted his/her life.
7. Administer psychological testing to assess the nature and severity of the emotional, cognitive, and behavioral impact of the trauma.
8. Encourage the client to develop alternative routes that don't involve exposure to the place of the traumatic event so as to avoid overwhelming stress reactions associated with exposure to the scene of the trauma.
9. Explore distorted cognitive messages that mediate negative emotional reactions to the trauma.
10. Help the client develop reality-based cognitive messages that will increase self-confidence and facilitate a reduction in fight-or-flight response.
11. Assist the client in developing behavioral coping strategies (i.e., increased social involvement, journaling, physical exercise) that will ameliorate the stress reactions.
12. Develop with the client a symptom onset timeline connected to the trauma.
13. Teach the client about the possible increase in emo-

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16. Recall the details of the traumatic event accurately and without cognitive distortions or emotional devastation. (9, 26, 27, 28)
 17. Place responsibility for the trauma on the perpetrator without equivocation. (29, 30)
 18. Verbalize an understanding of the benefits and the process of forgiveness of the perpetrator. (31, 32)
 19. Make a commitment to begin the process of forgiveness of the perpetrator. (33, 34, 35)
 20. Attend a survivors' support group. (36)
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- tional disturbance that is associated with the anniversary date or other significant days that trigger memories of the event.
 14. Prompt the client to talk about how the pain, sense of loss, or alteration of life that has resulted from the traumatic event has increased with the approaching anniversary of the event or other trigger events (e.g., holidays, vacation, graduation, etc.).
 15. Assist the client in preparing for trigger events or dates by planning involvement with people who have been supportive.
 16. Ask the client to express the emotions experienced on the day of the trigger event (e.g., anniversary day, holiday, etc.).
 17. Explore whether the client has had any flashback experiences to this trauma or previous traumatic events.
 18. Prompt the client to describe the traumatic experience within the session noting whether he/she is overwhelmed with emotions; monitor for decrease in intensity and frequency of flashback experiences as therapy progresses from week to week.
 19. Have the client write in a journal the recurring images or memories that are associated with the trauma.

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20. Refer the client to a physician for a psychotropic medication evaluation.
21. Monitor the client's medication compliance and effectiveness. Confer with the physician regularly.
22. Train the client in guided imagery techniques that induce relaxation.
23. Train the client in the progressive muscle relaxation procedure.
24. Utilize biofeedback techniques to facilitate the client learning relaxation skills.
25. Encourage the client to return to work and/or a normal daily routine; phase into these activities gradually but steadily if necessary.
26. Ask the client to carefully recall all the details of the traumatic event verbally and/or in writing.
27. Consult with law enforcement, relatives, or coworkers who have facts and/or details regarding the event, to corroborate and/or elaborate on the client's recall.
28. Go with the client to the scene of the event while offering desensitization techniques to reduce stress reactions as they develop.
29. Assign the client to write a letter to the perpetrator of the trauma, expressing the anger, anxiety, and/or de-

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pression that has resulted from the trauma.

30. Encourage and reinforce the client in placing clear responsibility for the traumatic event on the perpetrator(s) without taking on irrational, undue guilt for himself/herself.
31. Recommend that the client read *The Art of Forgiveness* (Smedes) to gain a healthier perspective on the benefits of forgiveness.
32. Teach the healing benefits and the process of forgiving anyone who has caused us severe pain.
33. Role-play with the client how an interaction with the perpetrator may take place, reinforcing the client's need for expression of pain as well as movement toward forgiveness.
34. Offer to meet with the client in a confrontation of the perpetrator of the trauma for the purpose of expressing pain, placing responsibility, and beginning the process of forgiveness.
35. Assign the client to write a letter to the perpetrator of the trauma for the purpose of expressing pain, placing responsibility, and beginning the process of forgiveness; process the letter in a session.
36. Refer the client to a survivors' support group that is

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focused on the nature of the trauma to which the client was exposed.

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DIAGNOSTIC SUGGESTIONS

Axis I:	308.3	Acute Stress Disorder
	309.24	Adjustment Disorder with Anxiety
	309.28	Adjustment Disorder with Mixed Anxiety and Depressed Mood
	300.02	Generalized Anxiety Disorder
	300.21	Panic Disorder with Agoraphobia
	300.01	Panic Disorder without Agoraphobia
	309.81	Posttraumatic Stress Disorder
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Axis II:	301.6	Dependent Personality Disorder
	301.50	Histrionic Personality Disorder
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CHILD ABUSE / NEGLECT

BEHAVIORAL DEFINITIONS

1. Wounds and/or bruises in different stages of healing that provide evidence of ongoing physical abuse.
2. Blood in underwear/genital region, sexually transmitted diseases, or tears in the vagina or anus that provide evidence of sexual abuse.
3. Report by self, parents, law enforcement, medical professionals, educators, and/or child protective services of intentional harm or a threat of harm by someone acting in the role of caretaker.
4. Caretaker fails to provide basic shelter, food, supervision, medical care, or support.
5. Coercive, demeaning, or overly distant behavior by a parent or other caretaker that interferes with normal social or psychological development.
6. Medical documentation of failure to thrive (weight below the 5th percentile for age) in infants or brain trauma secondary to violent shaking.
7. Inappropriate exposure to sexual acts or material, age-inappropriate knowledge and/or interest in sexual behavior (e.g., reaching for other's genitalia, masturbation of peers, discussing sexual activities, use of sexually oriented language, etc.).
8. Behaviors that are incongruent with chronological age such as thumb sucking, bed-wetting, clinging to the parent, and so on.
9. Repetitive play that reenacts situations regarding the abuse.
10. Nightmares, difficulty falling asleep.
11. Recurrent and intrusive recollections of the abuse.
12. Avoidance of situations related to the abuse, demonstrating fear when around the suspected abuser.
13. Explosive reactions of rage, anger, and/or aggression when exposed to the abuser or situations that trigger memories of the abuse.

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14. Pronounced change in mood and affect such as depression, anxiety, and irritability.
15. Withdrawal from activities with peers, family, and school that were previously a source of pleasure.

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LONG-TERM GOALS

1. Establish and maintain safety of the child.
2. Eliminate all abuse.
3. Develop appropriate boundaries within the family.
4. Return to previous level of psychosocial functioning as evidenced by an elimination of mood disturbance, a return to previously enjoyed activities, and the ability to recall the abusive incident(s) without regression.
5. Prevent the cycle of abuse from occurring with peers, spouses, the client's own children, and others.

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SHORT-TERM OBJECTIVES

1. Identify the nature, frequency, and intensity of the abuse. (1, 2, 3, 4, 18)
2. Verbalize an understanding of the need for a report of

THERAPEUTIC INTERVENTIONS

1. Establish rapport with the child by providing reassurance, compassion, and trust. Use age-appropriate terminology and interact on

CHILD ABUSE / NEGLECT 21

- suspected abuse to be given to child protective services or other law enforcement authorities. (5, 6, 10)
 3. Describe genitalia, what sex education/information has been obtained (and how recently), and what exposure to sexual practices he/she has had. (3, 7)
 4. Move to a safe environment. (8, 9, 10)
 5. Responsible adult authorizes and cooperates with the psychological and medical treatment of the child. (11)
 6. Receive necessary medical care to treat any injuries. (12, 13)
 7. School personnel collaborates with therapy goals and interventions. (14, 15)
 8. Express the feelings associated with the abuse. (16, 17, 18, 19)
 9. Identify the impact of the abuse upon social functioning. (20, 21, 22)
 10. Participate in a support group for abused children. (23)
 11. Participate in systematic desensitization. (24)
 12. Practice relaxation techniques. (25)
 13. Report an absence of intrusive memories, nightmares, and fear. (24, 25, 26, 27)
- the same level as the child (e.g., sitting on the floor).
 2. Utilize age-appropriate interview strategies (e.g., use of toys and dolls) to establish rapport.
 3. Complete a psychosocial assessment, focusing on sexual practices of the parents, privacy (or the lack of privacy) utilized in the home, recent sex education in school, extent of sexual education offered in the home.
 4. Obtain accurate corroboration of the traumatic event through collecting collateral information from child protective services, siblings, neighbors, teachers, and any written materials (e.g., child abuse investigation reports, medical reports, police reports, etc.).
 5. Coordinate a child abuse assessment with law enforcement or child protective services to prevent further traumatization and/or manufactured memories caused by multiple inquiries about the abuse.
 6. Explain to the child that you must notify appropriate authorities (e.g., law enforcement, child protective services, etc.) regarding suspected abuse of him/her. Inquire as to the results of their investigation.
 7. Using anatomically correct dolls or drawn outlines of the human body, ask the

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14. Parents receive and cooperate with treatment. (28, 29, 30, 31)
15. Parents attend support and/or psychotherapy group for abusive parents. (29, 30)
16. Parents attend parenting classes. (31)
17. Parents verbalize an increased understanding of appropriate discipline methods. (31, 32, 34)
18. Parents identify social stressors that are contributing to loss of control when angry. (33, 34)
19. Parents utilize community resources to assist in resolving psychosocial stressors. (29, 30, 31, 35, 36)
20. Parents identify childhood experiences that taught him/her that abusive behavior is to be expected, excused, and tolerated. (29, 30, 37, 38, 39)
21. Parents draw a genogram depicting a family history of violence and/or incest. (39)
22. The perpetrator verbalizes responsibility for the abuse. (40, 41)
23. The parent apologizes for the abuse. (41)
24. Cease assuming responsibility for the abuse and places blame on the perpetrator. (40, 41, 42)
25. Parents verbalize an increased understanding of child how he/she refers to his/her genitals and other body parts on the doll's body.
8. Request that the child be placed in protective custody (e.g., pediatric unit of the hospital, group home, foster care, etc.).
9. Determine that the abusive parent does not have contact with the child.
10. Inquire as to the child's and other household members' safety in each session. Report any abuse to the appropriate authorities.
11. Determine who has legal authority to authorize treatment of the child (child protective services, parents, foster parents, etc.), and obtain permission to treat the child for emotional and psychological consequences of abuse.
12. Refer the child to a pediatrician for an evaluation of any injuries, and monitor the caregiver's compliance with the assessment and treatment recommendations.
13. Refer the child to a pediatrician who is trained to conduct child sexual abuse examinations for evidence collection through the use of a rape kit.
14. Obtain releases of information from the identified responsible party, and contact the child's teacher to in-

CHILD ABUSE / NEGLECT 23

the appropriate boundaries
between family members.
(29, 30, 38, 43)

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quire about the child's behavior in school.

15. Notify the school of recent events, and encourage their cooperation in identification of emotional distress.
16. Utilize assessment scales to assess the mental status of the child [e.g., the Reynolds Child Depression Scale, the Symptom Checklist 90, or the Trauma Symptom Checklist for Children (Briere)].
17. Encourage the expression of emotions (fear, betrayal, rage, etc.) regarding the abuse.
18. Establish a rapport with the child with a parent present, and then meet with the child alone to further assess the abuse allegation and allow expression by the child without parental influence.
19. Utilize play therapy techniques to assist the child in expressing emotional reactions to the abuse.
20. Explore the child's sociability and self-confidence since the abuse.
21. Teach and reinforce the child's need to accept and think positively about himself/herself rather than define himself/herself as bad because of the bad things that were done to him/her.
22. Encourage the child to reach out to peers with self-

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confidence; use role playing and modeling to teach social skills.

23. Refer the child to a support group for abused children.
24. Have the child describe in graphic detail (e.g., sounds, sights, smells, emotions, touch/physical contact, etc.) their memories of the abuse. Begin with the least anxiety-provoking memories to assist with desensitization.
25. Teach the child relaxation techniques: deep-breathing exercises, progressive muscle relaxation, cue-controlled relaxation, and differential relaxation.
26. Monitor the child for signs and symptoms of acute and/or posttraumatic stress disorder. Treat accordingly. [See the chapters entitled “Posttraumatic Stress Disorder (PTSD)” and/or “Acute Stress Disorder” of this Planner].
27. Role-play with the child fear-producing situations and utilize relaxation techniques to cope with anxiety that is precipitated by the experience; encourage the child to practice this skill in real-life situations.
28. Collaborate with child protective services by ascertaining their plans regarding long-term custody of the child and treat-

CHILD ABUSE / NEGLECT 25

ment recommended for the parents. Monitor the parents' compliance with recommendations and notify child protective services of any noncompliance.

29. Require that the parents attend a psychotherapy group for abusive parents.
30. Refer the parents to a support group that will assist them in developing skills necessary to establish and maintain safety of the child such as Parents Anonymous, Parents United, or some similar group.
31. Refer the parents to parenting classes. Monitor their attendance by contacting the group facilitator. Confront the parents with any absences and/or notify the appropriate authorities.
32. Educate the parents on nonviolent discipline methods such as time-outs, removing privileges, and immediate consequences for undesired behaviors before they escalate.
33. Assist the parents in identifying any social stressors such as limited finances, isolation, or problems with housing that are contributing to the abuse in the home.
34. Educate the parents on anger management techniques (walking away, taking a deep breath, counting

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to 10, hugs-versus-hits philosophy) so as not to discipline their child when the parents are enraged/angered.

35. Educate the parents about community resources [housing programs, Aid to Families with Dependent Children (AFDC), Women with Infants and Children (WIC), etc.] that can assist in resolving social stressors.
36. Refer the parents to the local welfare department to identify programs for which they are eligible.
37. Inquire if the parent was abused during childhood, or witnessed abuse between her/his parents. Discuss how this has contributed to perpetrating abuse against their own child.
38. Assist the parents in identifying childhood events that taught them to excuse abusive behavior; teach appropriate limits and boundaries for behavior.
39. Assist the parents in drawing a genogram with notations indicating each relationship that contained emotional, verbal, and/or physical abuse, as well as sexual abuse and/or incest.
40. Conduct a family session where the child confronts the perpetrator with the abuse and its emotional and psychological consequences.

CHILD ABUSE / NEGLECT 27

Confront the perpetrator with the facts through the use of medical reports and the child's statements when he/she is minimizing or denying any aspect of the abuse.

41. Conduct a family session where the perpetrating parent apologizes for the abuse and agrees to a plan to prevent its recurrence.
42. When the child expresses guilt/self-blame, redirect him/her to view the event as something that happened beyond his/her control, placing the blame on the perpetrator.
43. Assist the parent in identifying and implementing changes (respecting privacy by closing doors, stopping any overt sexual behavior in front of the child, etc.) in the household that honor emotional, physical, and sexual boundaries.

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Axis I:	308.3	Acute Stress Disorder
	309.xx	Adjustment Disorder
	995.5	Neglect of Child (Victim)
	307.47	Nightmare Disorder
	313.81	Oppositional Defiant Disorder
	995.5	Physical Abuse of Child (Victim)
	309.81	Posttraumatic Stress Disorder
	309.21	Separation Anxiety Disorder
	995.5	Sexual Abuse of Child (Victim)

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Axis II:

V71.09	No Diagnosis
_____	_____
_____	_____

CRIME VICTIM TRAUMA

BEHAVIORAL DEFINITIONS

1. Exposure to a crime that involved death to someone else, actual or threatened death or serious injury to self (e.g., kidnapping, carjacking, home invasion/burglary, assault) or workplace crisis (robbery, hostage, bomb threat).
2. Subjective experience of intense fear, helplessness, or horror.
3. Recurrent, intrusive, traumatic memories, flashbacks, nightmares, and/or hallucinations related to crime.
4. Intense psychological distress during exposure to events, places, or people that are reminders of the crime.
5. Symptoms of increased arousal such as difficulty sleeping, irritability, poor concentration, hypervigilance, exaggerated startle response, motor restlessness, easily enraged, and/or frequent outbursts of anger.
6. Difficulty concentrating, anhedonia, and/or detachment or estrangement from others.
7. Physical symptoms of chest pain, chest pressure, sweats, shortness of breath, headaches, muscle tension, intestinal upset, heart palpitations, or dry mouth.

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LONG-TERM GOALS

1. Elimination of intrusive memories, nightmares, flashbacks, and hallucinations.
2. Assimilate the crime experience into life without ongoing distress.
3. Return to the levels of occupational, psychological, and social functioning that were present before the crime took place.
4. Feel empowered in daily functioning with a restored sense of dignity and an increased feeling of personal security.
5. Confront, forgive, or accept the perpetrator of the crime.

SHORT-TERM OBJECTIVES

1. Receive medical care for any injury that has resulted from the trauma. (1, 2)
2. File a report with law enforcement. (3)
3. Recall the details of the crime accurately and without cognitive distortions or emotional devastation. (4, 5, 6, 7, 19)
4. Describe the emotional reaction at the time of the crime taking place. (8, 9)
5. Describe the emotional reactions experienced since the crime was committed. (10, 11, 12)
6. Cooperate with psychological testing to determine the

THERAPEUTIC INTERVENTIONS

1. Assist in getting the person to an urgent care or emergency department for medical consultation.
2. Refer the client to a physician for a medical evaluation and treatment.
3. Refer the client to a local law enforcement agency to file a report of the crime.
4. Ask the client to carefully recall all the details of the crime verbally and/or in writing.
5. Consult with law enforcement, relatives, or coworkers who have facts and/or details regarding the crime, to corroborate and/or elaborate on the client's recall.

- severity of the impact of the crime. (11)
7. Describe the impact the crime has had upon personal, social, occupational, and daily functioning. (11, 13, 14, 15)
8. Report an increased sense of control. (16, 17, 18, 19)
9. Report an absence of intrusive thoughts, memories, and/or flashbacks. (20, 21)
10. Participate in eye movement desensitization and reprocessing (EMDR). (21)
11. Verbalize an increased understanding of the role of anger and how to manage it. (22, 23)
12. Practice relaxation techniques when feeling anxious or threatened. (24, 25)
13. Identify people who can be relied upon for social support. (26, 27)
14. Report an increased feeling of safety and security in the home. (28, 29)
15. Stop looking for the perpetrator in society. (30, 31)
16. Place responsibility for the trauma on the perpetrator without equivocation. (32, 33, 34)
17. Verbalize an understanding of the psychological benefits and the process of forgiveness. (35, 36, 37, 38)
18. Confront the perpetrator with the psychosocial consequences.
6. Teach the client how to use an automatic thought record to identify and challenge cognitive distortions related to the crime(s).
7. Prompt the client to describe the traumatic experience, noting whether he/she is overwhelmed with emotions.
8. Explore the client's emotional reaction at the time of the trauma.
9. Teach the client how fear inhibits people from fighting back when threatened, and help the client realize that his/her survival was the most important issue.
10. Explore the client's emotional reactions experienced since obtaining physical safety from the crime (i.e., fear, revenge, anger, paranoia, etc.).
11. Complete the Trauma Symptom Inventory (Briere), the Beck Depression Scale, or the Symptom Checklist 90 to determine the severity of the impact of the crime.
12. Monitor the client for a persistent mood disorder (e.g., depression or anxiety). (See "Depression" or "Anxiety" in this Planner.)
13. Ask the client to identify how the crime has negatively impacted his/her interaction with friends and family.

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- quences of victimization.
(34, 37, 38)
19. Receive services from a victim witness program to assist with emotional and financial support. (39)
 20. Participate in court proceedings. (37, 38, 40)
 21. Verbalize emotional reactions to the perpetrator's release from jail/prison. (41)
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14. Ask the client to make a list of the ways the crime(s) has impacted his/her life and to process this list with the therapist.
 15. Assess ways in which the client feels vulnerable in his/her home, car, job, and relationships.
 16. Train the client in assertiveness skills to increase his/her sense of control and decrease feelings of vulnerability.
 17. Explore whether the client feels a loss of control over his/her emotions. Identify ways to recapture that control through use of journaling, cognitive restructuring, focused time spent on one particular thought, and so forth.
 18. Utilize the therapeutic game Stop, Relax, and Think (Shapiro) to assist the client in developing self-control.
 19. Explore distorted cognitive messages that mediate negative emotional reactions to the trauma.
 20. Assess and treat the client for intrusive thoughts, memories, flashbacks, and/or nightmares, and so forth. (See "Posttraumatic Stress Disorder (PTSD)" or "Acute Stress Disorder" in this Planner.)
 21. Conduct EMDR to reduce anxiety.

CRIME VICTIM TRAUMA 33

22. Interpret anger as a symptom of feeling helpless. Process reactions to interpretations in session.
23. Teach releasing anger physically by hitting a punching bag or pillows; recommend journaling after such an exercise to identify targets of anger.
24. Teach the client relaxation techniques: deep-breathing exercises, progressive muscle relaxation, cue-controlled relaxation, and differential relaxation.
25. Assist the client in developing behavioral coping strategies (i.e., increased social involvement, journaling, physical exercise) that will alleviate the stress reactions.
26. Inquire as to the nature of the client's social support system and encourage him/her to utilize this resource during treatment.
27. Have the client draw an eco-map to graphically depict available social support. Encourage the client to consider a full range of possibilities, including: friends, family, religious leaders, coworkers, neighbors, classmates, and so forth.
28. Walk through the client's home, identifying ways that the home may be made more secure.

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29. Review with the client changes that can be made in his/her house, such as installing dead-bolt locks, keeping curtains closed while at home, purchasing a nonstationary phone and/or caller ID, and/or installing a home security system to increase his/her sense of safety.
30. Ask the client if he/she looks at strangers in trying to find the perpetrator. Educate him/her on how this provokes anxiety. Encourage him/her to develop different ways to behave in public, such as avoiding eye contact and practicing relaxation techniques.
31. Utilize a professional sketch artist to compose a drawing of the perpetrator. Remind the client to look at this picture before going into public places to challenge the client's belief that strangers are the perpetrator.
32. Confront the client when he/she takes responsibility for the crime and assist him/her with placing the blame on the perpetrator.
33. Ask the client to verbalize feelings of guilt or shame about not resisting the perpetrator hard enough and allowing the crime to take place.
34. Ask the client to write a letter to the perpetrator that

CRIME VICTIM TRAUMA 35

expresses his/her emotional reactions to the trauma.

35. Recommend that the client read *The Art of Forgiveness* (Smedes) to provide information on the psychological benefits of forgiveness.
36. Teach the healing benefits and the process of forgiveness of anyone who has caused us severe pain.
37. Prepare the client for interaction with the perpetrator by role playing. Assist the client in expressing his/her emotional reactions and direct him/her to begin the forgiveness process.
38. Provide support for the client in a confrontation of the perpetrator. Assist the client in expressing pain, placing responsibility upon the perpetrator, and/or beginning the process of forgiveness.
39. Educate the client on the services available through the victim witness program and refer him/her to the same.
40. Encourage the client to be present during the court proceedings of the perpetrator; process his/her emotional reactions.
41. Prepare the client for emotional reactions related to the perpetrator's release by exploring his/her feelings and thoughts associated with it. Review previously

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learned skills and strategies such as assertiveness training and safety precautions.

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DIAGNOSTIC SUGGESTIONS

Axis I:	308.3	Acute Stress Disorder
	309.xx	Adjustment Disorder
	296.xx	Bipolar I Disorder
	300.4	Dysthymic Disorder
	300.02	Generalized Anxiety Disorder
	296.xx	Major Depressive Disorder
	309.81	Posttraumatic Stress Disorder
Axis II:	301.82	Avoidant Personality Disorder
	301.83	Borderline Personality Disorder
	301.50	Histrionic Personality Disorder

CRITICAL INCIDENTS WITH EMERGENCY SERVICE PROVIDERS (ESPs)

BEHAVIORAL DEFINITIONS

1. Serious injury or death of a coworker in the line of duty.
2. Suicide or unexpected death of a coworker.
3. Serious injury or death of a civilian as a result of emergency service activity.
4. Subjective experience of distress after providing emergency services to a relative, friend, or coworker.
5. Serious injury, death, and/or violence to a child.
6. Death of a patient following prolonged rescue attempts/heroic efforts.
7. Rescue incident attracting unusually extensive media attention.
8. Multiple fatalities or a mass-casualty incident.
9. Shooting of a subject; suicide of a subject in custody (e.g., hanging in jail) or use of deadly force.
10. Sense of helplessness, feeling out of control, emotional numbness, needing to avoid contact with others, loss of motivation, feelings of inadequacy and/or guilt.
11. Headaches, nausea, shaking/tremors, fatigue, intestinal upset, diarrhea, increased blood pressure, change in appetite or exhaustion.
12. Experiencing flashbacks, replaying the event over and over in the mind, sense of unreality or disbelief, impaired memory, short attention span, angry thoughts, and/or increased worry.
13. Withdrawing from social, recreational, and/or occupational activities.
14. Increased use of alcohol or drugs.
15. Resistance to communication, or excessive use of “black” humor.

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LONG-TERM GOALS

1. Regain control of emotions and return to previous level of functioning.
2. Gain an understanding of the critical incident and its impact upon cognitive, behavioral, physical, and emotional functioning.
3. Reestablish a sense of equilibrium, trust, and hope.
4. Diminish flashbacks, intrusive images, and distressing emotional reactions regarding the critical incident.
5. Regain confidence in ability to perform job duties.

SHORT-TERM OBJECTIVES

1. Verbalize current emotional reactions to the incident.
(1, 2, 3)
2. Verbalize an understanding that emotional reactions are a normal response to the incident. (2, 3)
3. Participate in a critical incident stress debriefing.
(4, 5, 6)

THERAPEUTIC INTERVENTIONS

1. Explore the client's emotional reactions following the incident.
2. Encourage and facilitate sharing by the client with a professional peer of the client's to validate the normalcy of his/her emotions experienced.

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4. Identify any bodily injury or physical symptoms that resulted from the incident and receive medical care for the same. (7)
5. Describe the facts of the incident, recalling information experienced through all of his/her senses (sight, smell, touch, etc.). (6, 8, 9, 10)
6. Describe the emotions that were experienced at the time of the incident. (11)
7. Identify the aspects of the incident that were most disturbing. (11, 12, 13)
8. Identify the impact that the traumatic event has had upon daily functioning. (14, 15, 16, 17)
9. Verbalize an understanding of the causes of anger related to the incident. (17, 18)
10. Report confidence in and stop second-guessing actions taken during the incident. (19, 20)
11. Report the termination of flashbacks. (21, 22)
12. Increase the frequency and depth of social activity with friends or family. (23, 24, 25, 26)
13. Write a daily social activity schedule. (26)
14. Avoid and/or minimize contact with media, community members, and others who inquire about the incident. (27, 28)
3. Provide written information on critical incident stress reactions to the client for his/her review.
4. Contact a local critical incident stress management (CISM) team to provide a critical incident stress debriefing (CISD).
5. Contact the International Critical Incident Stress Foundation (ICISF) to find a local CISM team.
6. Encourage participation in a CISD that is facilitated by an ICISF-trained debriefer.
7. Inquire as to the medical care that has been received and refer the client to a physician as appropriate.
8. Clarify what the client's role was at the incident.
9. Ask the client to obtain a copy of his/her written report to review the facts of the incident. Identify any cognitive distortions and redirect to more realistic alternatives.
10. Gently ask the client to recall what he/she saw, heard, smelled, and touched while being involved in the incident.
11. Explore the client's emotional reaction at the time of his/her providing emergency services.
12. Ask the client if he/she could change one aspect of the incident without chang-

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15. Report adherence to a nutritional dietary plan. (29, 30, 31)
 16. Report a reduction of sleep disturbance, distressing dreams, or fear of sleeping. (32, 33)
 17. Return to open communication with family, friends, and coworkers. (34, 35)
 18. Identify distorted cognitive messages that promote fear, and replace those messages with reality-based self-talk that nurtures confidence and calm. (36, 37)
 19. Implement behavioral coping strategies that reduce tension. (38, 39, 40, 41, 42)
 20. Attend the funeral of a coworker who has died. (43)
 21. Identify cumulative stress reactions. (44)
 22. Employ previously healthy stress management strategies to reduce current emotional reactions. (45)
 23. Identify the use of alcohol or other substances as a means of coping with stress. (46)
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- ing the outcome, what would that be.
 13. Probe how this incident relates to something in the client's personal life that may be causing a magnification of the emotions.
 14. Assess for possible transference of unresolved issues from a previous incident onto this incident.
 15. Ask the client to identify how the traumatic event has negatively impacted his/her life.
 16. Administer the Trauma Symptom Inventory (Briere) to assess the nature and severity of the emotional, cognitive, and behavioral impact of the trauma.
 17. Probe why, at what, and with whom the client is angry; process the anger to resolution.
 18. Explore the client's feelings of fear, vulnerability, frustration, or helplessness as causes of angry reactions; encourage acceptance of these feelings as normal rather than becoming angry over them.
 19. Ask the client to share his/her thought process before and during the incident that led to his/her actions; reassure him/her of the automatic response that comes with being well trained.

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20. Confront the client when he/she negatively evaluates his/her performance during the incident and redirect him/her toward more realistic perceptions by focusing upon the facts of what did take place and his/her professional response.
21. Explore whether the client has had any flashback experiences to this critical incident or previous traumatic events.
22. Determine if the flashbacks are being triggered by something that reminds him/her of the critical incident; explain how flashbacks will diminish as the feelings and facts about the trauma are shared.
23. Educate the client of the psychological consequences of social isolation and encourage him/her to increase his/her level of activity.
24. Encourage the client to attend at least two social events with family or friends.
25. Assist the client in identifying social activities that were a source of pleasure prior to the incident and encourage him/her to resume these activities.
26. Assist the client in writing a daily schedule of events that includes socialization and encourage him/her to follow the schedule.

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27. Educate the client about the psychological consequences (e.g., feelings of helplessness, guilt, loss of confidence in rescue work abilities, etc.) of continued exposure to the incident precipitated by contact with reporters, community members, and others who want to discuss the incident; encourage the client to avoid these people.
28. Role-play with the client how he/she will politely respond to those in the community asking questions that he/she does not want to answer.
29. Arrange for the client to have an appointment with a nutritionist. Inquire as to the recommendations and monitor the client's compliance.
30. Encourage the client to avoid caffeine and other foods that stimulate his/her nervous system.
31. Ask the client to keep a log of his/her food intake; encourage eating at regular intervals even though grief may reduce appetite.
32. Assign the client homework of keeping a journal of dreams, nightmares, and disturbing thoughts that are affecting his/her sleep patterns. Process the journal information in session.
33. Process the client's fear of sleeping as possibly a result

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- of having nightmares or of having to face reality when he/she wakes up.
34. Conduct a conjoint session with the client's spouse/family to facilitate effective communication skills.
 35. Encourage the client to talk with peers, supervisors, or his/her spouse about the thoughts and emotions that he/she is experiencing since the incident.
 36. Explore the client's distorted cognitive messages that mediate negative emotional reactions to trauma.
 37. Help the client develop reality-based cognitive messages that will increase his/her self-confidence and facilitate a reduction in fight-or-flight response.
 38. Administer the eye movement desensitization and reprocessing (EMDR) technique to reduce immediate tension.
 39. Teach the client relaxation skills utilizing biofeedback techniques.
 40. Train the client in progressive muscle relaxation.
 41. Train the client in guided imagery techniques to induce relaxation.
 42. Encourage the use of strenuous physical exercise alternating with relaxation to alleviate physical stress reactions.

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43. Encourage the client to attend the funeral of his/her deceased coworker to facilitate the grieving process. Explore his/her reactions afterward in session.
44. Assess the client for cumulative stress reactions (e.g., chronic fatigue, irritability, or somatic complaints).
45. Explore the client's history of experiencing other traumatic events and determine what coping mechanisms were used to cope with that/those event(s); encourage the use of those healthy strategies again.
46. Complete a substance abuse evaluation and refer the client to substance abuse treatment as appropriate.

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DIAGNOSTIC SUGGESTIONS

Axis I:	308.3	Acute Stress Disorder
	309.xx	Adjustment Disorder
	305.00	Alcohol Abuse
	300.4	Dysthymic Disorder
	296.2x	Major Depressive Disorder, Single Episode
	V65.2	Malingering
	304.80	Polysubstance Dependence
	309.81	Posttraumatic Stress Disorder
	300.81	Somatization Disorder
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Axis II:	301.4	Obsessive-Compulsive Personality Disorder
	301.9	Personality Disorder NOS
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